114.3 CMR 13.00: RATES FOR FREESTANDING CLINICS PROVIDING ABORTION AND STERILIZATION SERVICES

Section

13.01: General Provisions

(1) Scope and Effective Date. 114.3 CMR 13.00 shall govern the rates of payment by governmental units to eligible providers for abortion and sterilization services to publicly aided individuals. 114.3 CMR 13.00 shall be effective on March 1, 2002.

(2) Coverage. 114.3 CMR 13.00 and the rates of payment contained herein shall apply to abortion and sterilization services rendered by eligible providers in an ambulatory clinic setting. The rates of payment under 114.3 CMR 13.00 are full compensation for all services rendered.

(3) Coding Updates and Corrections. The Division may publish procedure code updates and corrections in the form of an Informational Bulletin. Updates may reference coding systems, including but not limited to, the American Medical Association's *Current Procedural Terminology* (CPT). The publication of such updates and corrections will list:

(a) codes for which the code numbers only change, with the corresponding cross reference between existing and new code;
(b) deleted codes for which there is no corresponding new code; and
(c) codes for entirely new services that require pricing. The Division will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(4) Copyright Notice. For more detail on CPT refer to the Physician's Current Procedural Terminology, copyright 2001 by the American Medical Association.

(5) Authority. 114.3 CMR 13.00 is adopted pursuant to M.G.L. c. 118G.

13.02: General Definitions

Ambulatory Abortion or Sterilization Clinic. An ambulatory clinic licensed by the Massachusetts Department of Public Health and in compliance with its "Regulations for Ambulatory Gynecological Surgery in Licensed Clinics".

CPT. The Physicians' *Current Procedural Terminology* (CPT) is developed and maintained by the American Medical Association and updated on a yearly basis.

Division. The Division of Health Care Finance and Policy established under M.G.L. Chapter 118G.

Eligible Provider. Licensed freestanding ambulatory clinics providing abortion and/or sterilization services which meet such conditions of participation as may be required by a governmental unit purchasing such services.

Modifier. Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two letter or numeric designation.

13.03: General Rate Provisions

(1) Rate Determination. Rates of payment for abortion and sterilization services shall be the lower of the provider's charge to the general public or the allowable fees set forth in 114.3 CMR 13.03.

(2) Abortion Services. The rates for an induced abortion, physician and clinic services shall include preoperative evaluation and counseling, laboratory services, surgery, anesthesia and postoperative care due to complications. The post-abortion visit rate shall constitute full compensation for routine follow-up care for abortion patients who return for such care.

(3) Sterilization Services. The rates of payment for Sterilization Services represent full compensation for these services, which shall include preoperative evaluation and counseling, laboratory services, surgery, anesthesia and postoperative care.

(4) Modifiers.

(a) Modifier –YW pertains to the vasectomy and laparoscopy services only. The addition of the modifier "YW" to the appropriate procedure code allows an additional ten percent of the allowable fee contained in 114.3 CMR 13.03(5) to be paid to the clinic for general anesthesia services.

(b) Modifier –51 pertains to multiple procedures. This modifier must be used to report multiple procedures performed at the same session. The service code for the major procedure or service must be reported without a modifier. The secondary, additional or lesser procedure(s) must be identified by adding the modifier –51 to the end of the service code for the secondary procedure(s). The addition of the modifier '51' to the second and subsequent procedure codes allows 50% of the allowable fee contained in 114.3 CMR 13.03(5) to be paid to the eligible provider.

(5) Maximum Allowable Rates.

CODE	MODIFIER	RATE	DESCRIPTION
55250		269.05	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55450		269.05	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
58600		696.94	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral approach
58670		649.96	Laparoscopy, surgical, with fulguration of oviducts (with or without transection)
58671		684.74	Laparoscopy, surgical; with occlusion of oviducts by device (e.g. band, clip or Falope ring)
59820		309.66	Treatment of missed abortion, completed surgically - first trimester (includes physician's charges and clinic services)
59840		331.00	Induced abortion, by dilation and curettage (first trimester; includes physician's charges and clinic services with either I.V. sedation or general anesthesia)
59840	-TF	450.00	Induced abortion, by dilation and curettage (12.1 to 13.9 weeks) (includes physician's charges and clinic services with either I.V. sedation or general anesthesia)
59840	-TG	634.70	Induced abortion, by dilation and curettage (14 to 18.9 weeks) (includes physician's charges and clinic services with either I.V. sedation or general anesthesia)
59841		331.00	Induced abortion, by dilation and evacuation - (first trimester; includes physician's charges and clinic services)

CODE	MODIFIER	RATE	DESCRIPTION
59841	-TF	450.00	Induced abortion, by dilation and evacuation - (12.1 to 13.9 weeks) (includes physician's charges and clinic services)
59841	-TG	634.70	Induced abortion, by dilation and evacuation - (14 to 18.9 weeks) (includes physician's charges and clinic services)
J2790		I.C.	Injection, RHO (D) immune globulin, human, one dose package (when required only, reimbursed at the actual wholesale cost of the serum. A copy of the purchase invoice must be submitted with the claim form)
S0199		289.71	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g. patient counseling, office visits confirmation of pregnancy by Hcg, Ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs
S0190		I.C.	Mifepristone, Oral, 200MG
S0191		I.C.	Misoprostol, Oral, 200MCG

The Rates of payment for the following procedures shall be based upon 114.3 CMR 12.00

CODE	DESCRIPTION
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. (Post abortion check up visit) (routine follow-up care only)
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem focused history; - an expanded problem focused examination; - medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. (Post abortion check up visit) (routine follow-up care only)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive history; - a comprehensive examination; - medical decision making of high complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. (Post abortion check up visit) (routine follow-up care only)

The Rates of payment for the following procedures shall be based upon 114.3 CMR 18.00:

CODE	DESCRIPTION
76805	Ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)
76815	limited (fetal size, heart beat, placental location, fetal position, or emergency in the delivery room)

13.04 Reporting Requirements

(1) Upon the request of the Division an eligible provider of abortion or sterilization services shall forward to the Division the following information within 90 days of a written request.
   (a) an "ambulatory surgical clinic cost report" and supplemental schedules supplied by the Division.
   (b) financial statements certified by a certified public accountant. In the absence of certified statements an eligible provider may submit uncertified statements or a Balance Sheet and Operating Statement prepared by the clinic.
   (c) a complete schedule of charges to the public. Additionally, the eligible provider shall notify the Division of any change in charge to the public during the year.

(2) Additional Information Requested by the Division. Each eligible provider shall file such additional information as the Division may from time to time request other than that specified in 114.3 CMR 13.04(1) no later than 30 days after a written request.

(3) Examination of Records. Each eligible provider shall make available all records relating to its operation for audit, if requested by the Division.

(4) Accurate Data. All reports, schedules, additional information, books and records which are filed or made available to the Division shall be certified under pains and penalties of perjury as true, correct, and accurate by the Executive Director or Financial Officer of the eligible provider.

13.05: Severability

The provisions of 114.3 CMR 13.00 are hereby declared to be severable and if any such provisions or the application of such provisions to any person or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 13.00: M.G.L. c.118G.